DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 10/20/13

PRINTED: 09/10/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445421	A. BUILDING _____ B. WING _____	09/05/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF SPARTA	508 MOSE DRIVE SPARTA, TN 38583

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An annual Recertification survey and complaint investigation #32346, were completed on September 5, 2013, at Life Care of Sparta. No deficiencies were cited related to the complaint investigation under 42 CFR Part 483, Requirements for Long Term Care Facilities.	F 000	Life Care Center of Sparta is committed to upholding the highest standard of care for its residents. This includes substantial compliance with all applicable standards and regulatory requirements. The facility respectfully works in cooperation with the State of Tennessee Department of Health toward the best interest of those who require the services we provide.	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update	F 157	While this Plan of Correction is not to be considered an admission of validity of any findings, it is submitted in good faith as a required response to the survey conducted September 3-5, 2013. This Plan of Correction is the facility's allegation of substantial compliance with Federal and State requirements. F157 1. Resident #46 was discharged prior to survey. 2. a) All residents who had significant change in condition were audited by Director of Nursing /Assistant Director of Nursing by September 20, 2013. b) No other residents who had a significant change in condition were affected by the alleged deficient practice. 3. a) The Staff Development Coordinator will educate 100% of licensed nurses by September 27, 2013 regarding timely notification of physician when a significant change in a resident's condition occurs.	9/20/2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Cathy M Howe — TITLE: Executive Director — (X6) DATE: 9.20.13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to notify the physician timely of significant changes in a resident's (#46) condition for one resident of twenty-nine residents reviewed. The findings included: Resident #46 was admitted to the facility on July 16, 2013, with diagnoses including End Stage Renal Disease, Renal Dialysis, Anemia Chronic Airway Obstruction, Hypertension, Diabetes Mellitus, Peripheral Vascular Disease, Osteomylitis of the Left Ankle, and Infection. Medical record review of the Nursing Notes dated August 17, 2013, at 8:10 a.m., revealed "Late Entry for 8-17-13 @ (at) 5 am (5 a.m.) Upon entering the res.'s (resident's) room to adm. (administer) am (morning) meds (medications) and check BS (blood sugar), noted the resident to be unresponsive...checked BS -meter reading LOW (Equal to or below 40) Standing Order Utilized...Vital signs temp (temperature) 99.3 Pulse 32/min (thiry two beats per minute) Resp. Rate 22/min (Respiratory rate twenty two breaths per minute) Blood Pressure 144/115...MD (Medical Doctor) notified (no time documented), and new order noted to send to...hospital for eval and tx (evaluation and treatment)...EMS (Emergency Medical Services) here for transport @ 5:40 am and EMT (Emergency Medical Technician) assessed res. (resident) and found	F 157	b) The Director of Nursing/Assistant Director of Nursing will review nursing documentation of residents who have been identified as having a significant change in their condition to audit for compliance of timely physician notification for 3 months. 4. a) Director of Nursing/Assistant Director of Nursing will present results of audits to the Performance Improvement Committee. b) The Performance Improvement Committee consisting of Executive Director, Director of Nursing, Medical Director, Director of Rehabilitation, Director of Health Information, Director of Clinical Nutrition, Director of Maintenance, Director of Environmental Services, Business Office Manager, Director of Recreational Services, and Staff Development Coordinator will review the results. If it is deemed necessary by the committee, additional education may be provided, the process evaluated/revised, and/or the audits reviewed for 3 months or until 100% compliance is achieved.	

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F 157	Continued From page 2 res to be without pulse and respiration..." Medical record review of the County EMS Run Sheet dated August 17, 2013, revealed "Arrived patient 8/17/2013 5:44:00...Notes/Narrative...Pt was found unresponsive, no pulse, no respirations...taken to ambulance...asystole (without electrical activity in the heart) 08/17/13 05:49:00 in 3 leads...pt was tx (transported) to...ER (Emergency Room) to be pronounced..." Medical record review of the Nursing Home to Hospital Transfer Form, undated and untimed revealed the resident was transferred to the "...hospital, with vital signs of temperature of 99.3, pulse of 32, respiratory rate of 22 and an oxygen saturation of 88% (percent) with oxygen at 4 liter via NC (nasal cannula)..." Telephone interview with the resident's Physician on September 5, 2013, at 10:18 a.m., confirmed the resident was "very compromised" with end stage renal disease, on dialysis three times weekly, and the facility had called regarding the resident but could not remember the time of the call. The Physician confirmed "I would expect to be informed immediately if the patient's pulse rate were 32 beats per minute..."	F 157		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced	F 282	F282 1. Padding was added to Resident #36 side rails on September 03, 2013. Staff working with Resident #36 were immediately educated on September 03, 2013 by Assistant Director of Nursing that Resident #36 should have padded side rails at all times.	9/03/2013

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F 282	Continued From page 3 by: Based on medical record review, observation, and interview, the facility failed to follow the care plan for padded side rails for one resident (#36) of twenty-nine residents reviewed. The findings included: Resident #36 was admitted to the facility on July 14, 2012, and readmitted to the facility on October 8, 2012, with diagnoses including Congestive Heart Failure, Atrial Fibrillation, Cardiac Pacemaker, Chronic Obstructive Pulmonary Disease, Peripheral Vascular Disease, Insomnia, Aortic Valve Disorder, Anemia, and Depressive Disorder. Observation on September 3, 2013, at 12:26 p.m., in the resident's room revealed bruised areas to the top of both hands. Interview at the time of the observation revealed the bruised areas "were normal wear and tear, if it gets bumped will bruise." Further interview revealed the resident was on anti-coagulant medication. Observation on September 3, 2013, at 3:03 p.m., of the resident in the bed in the resident's room revealed the side rail was in the raised position. Further observation revealed the side rail was not padded. Medical record review of the August 2013 Physician's Recapitulation Orders revealed the resident was receiving Coumadin, an anti-coagulant medication. Review of the Care Plan dated February 6, 2013, and updated on July 10, 2013, revealed "...at risk of alteration in skin integrity due to impaired	F 282	2. a) Assistant Director of Nursing audited 100% of care plans/care directives on September 03, 2013. b) No other residents with padded side rails were affected by the alleged deficient practice. 3. a) The Staff Development Coordinator will educate 100% of licensed nurses and certified nursing assistants on following resident's care plans/care directives regarding side rail pads by September 27 2013. b) The Director of Nursing/Minimum Data Set Nurse will audit residents weekly who have been care planned to have padded side rails for compliance for 3 months. 4. a) Director of Nursing/Minimum Data Set Nurse will present results of audits to the Performance Improvement Committee.	9/03/2013

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F 282	Continued From page 4 mobility, incontinence and use of medication...APPROACHES:...7/10/13 add padding to side rail..." Interview with the Assistant Director of Nursing, on September 5, 2013, at 8:55 a.m., in the resident's room confirmed the side rails were not padded. Further interview confirmed the facility had failed to follow the Care Plan for the padded side rails.	F 282	b) The Performance Improvement Committee consisting of Executive Director, Director of Nursing, Medical Director, Director of Rehabilitation, Director of Health Information, Director of Clinical Nutrition, Director of Maintenance, Director of Environmental Services, Business Office Manager, Director of Recreational Services, and Staff Development Coordinator will review results. If it is deemed necessary by the committee, additional education may be provided, the process evaluated/revised, and or the audits reviewed for 3 months or until 100% compliance is achieved.	
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility policy, and interview, the facility failed to have a justification for the use of an indwelling catheter for one resident (#26) of twenty-nine residents reviewed. The findings included: Resident #26 was admitted to the facility on May 22, 2012, and readmitted to the facility on February 14, 2013, with diagnoses including	F 315	F315 1. The Director of Nursing educated the Licensed Practical Nurse that did not complete catheter justification on facility's policy on completion of foley catheter justification worksheet on September 16, 2013. 2. a) The Assistant Director of Nursing audited 100% of residents with foley catheters on September 04, 2013. b)No other residents with foley catheters were affected by the alleged deficient practice.	9/16/2013 9/04/2013

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F 315	Continued From page 5 Congestive Heart Failure, Altered Mental Status, Diabetes Mellitus Type II, Hypertension, Anxiety State, Depressive Disorder, Alzheimer's Disease, Atrial Fibrillation, Senile Dementia with Delusional Features, History Malignant Neoplasm of Breast, Psychosis, Insomnia, and Coronary Atherosclerosis. Medical record review of a Physician Telephone Order dated July 23, 2013, revealed "...insert...foley catheter...indication/diagnoses Comfort Measures..." Review of facility policy, Indwelling Catheters, revealed "Policy...A client who enters (named facility) without an indwelling catheter shall not be catheterized unless the person's clinical condition demonstrates that catheterization is necessary...Intent:...An indwelling catheter shall not be used unless there is a valid medical justification...Procedures: 3. b. Insert urinary catheter only when justified medically and ordered by the attending physician...4. Perform a comprehensive assessment that addresses those factors that predispose the resident to the development of urinary incontinence and/or use of an indwelling catheter. A comprehensive assessment should include: a. The risks and benefits of an indwelling...catheter...c. factors supporting medical justification for the initiation of, and continuing need for the catheter use..." Interview with the Minimum Data Set Coordinator and Licensed Practical Nurse #3, at the Orchid nursing station on September 4, 2013, at 3:24 p.m., confirmed the foley catheter was inserted on July 23, 2013, and the facility had failed to complete the catheter assessment. Further interview confirmed the facility did not have	F 315	3. a) The Staff Development Coordinator will educate 100% of licensed nurses on following facility's policy on foley catheters by September 27, 2013. b) The Director of Nursing/Assistant Director of Nursing will audit residents with foley catheters weekly for compliance for 3 months. 4. a) Director of Nursing/Assistant Director of Nursing will present results of audits to the Performance Improvement Committee. b) The Performance Improvement Committee consisting of Executive Director, Director of Nursing, Medical Director, Director of Rehabilitation, Director of Health Information, Director of Clinical Nutrition, Director of Maintenance, Director of Environmental Services, Business Office Manager, Director of Recreational Services, and Staff Development Coordinator will review results. If it is deemed necessary by the committee, additional education may be provided, the process evaluated/revised, and or the audits reviewed for 3 months or until 100% compliance is achieved.	

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F 315	Continued From page 6 medical justification for the use of the catheter at the time of the insertion on July 23, 2013, and the facility had failed to follow the facility policy.	F 315		
F 356 SS=F	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced	F 356	F356 1. The nurse staffing information was updated immediately on September 03, 2013. 2. Staff Development Coordinator will educate 100% of licensed nurses that accurate staffing information must be updated on the staffing board at midnight each night by September 27 2013. 3. a) Staff Development Coordinator will educate 100% of licensed nurses that accurate staffing information must be updated on the staffing board at midnight each night by September 27 2013. b) The Director of Nursing/Assistant Director of Nursing will audit for compliance 5 times per week for 3 months. 4. a) Director of Nursing/Assistant Director of Nursing will present results of audits to the Performance Improvement Committee.	9/03/2013

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F 356	Continued From page 7 by: Based on observation and interview, the facility failed to post nurse staffing information daily with the current date. The findings included: Observation on September 3, 2013, at 9:35 a.m., in the facility lobby revealed a Nurse Staffing posting dated September 1, 2013. Interview with the Assistant Director of Nursing on September 3, 2013, at 9:50 a.m., confirmed the date was not current.	F 356	b) The Performance Improvement Committee consisting of Executive Director, Director of Nursing, Medical Director, Director of Rehabilitation, Director of Health Information, Director of Clinical Nutrition, Director of Maintenance, Director of Environmental Services, Business Office Manager, Director of Recreational Services, and Staff Development Coordinator will review results monthly. If it is deemed necessary by the committee, additional education may be provided; the process evaluated/revised and or the audits reviewed for 3 months or until 100% compliance is achieved.	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility dietary department failed to maintain dietary equipment in a sanitary manner. The findings included: Observation on September 3, 2013, at 2:30 p.m., and interview with the Dietary Manager present	F 371	F371 1. The range top, grill, back splash, and can opener slot were immediately cleaned on September 03, 2013. 2. a) Maintenance Department removed the back splash and shelf from the kitchen to be sanded and pressure washed on September 13, 2013. The shelf will not be replaced in kitchen.	9/03/2013 9/13/2013

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F 371	Continued From page 8 during the observation confirmed the following: 1.)The range top, back splash and shelf had an accumulation of blackened debris. 2.)The grill, connected to the range top, had an accumulation of blackened debris. 3.)The can opener slot had sticky blackened debris present.	F 371	b) Dietary associates will wipe up spills as they occur on the range top and grill. Each evening, dietary associates will clean cast iron grates, burner area, grill, and back splash to remove any blackened debris accumulated.	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to	F 431	c) On September 16, 2013, a replacement can opener and base was ordered and was installed by the Maintenance Department on September 19, 2013. Dietary associates will clean can opener slot after each meal to remove any blackened debris accumulated. 3. a) Dietary Manager will in-service 100% of dietary associates on cleaning schedule and the importance of maintaining sanitary dietary equipment, by September 27 2013. b) Dietary Manager/ Director of Nutritional Services will audit sanitation of range top, grill, back splash, and can opener slot five times per week for 3 months.	9/19/2013

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F 431	Continued From page 9 abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and interview, the facility failed to insure multi-dose medication vials were properly stored on one of four medication carts reviewed. The findings included: Observation on September 5, 2013, at 10:40 a.m., of the Orchid short hall medication cart at the Orchid nursing station revealed one multi-dose vial of Injectable Lidocaine 1%, opened, undated, and without a label. Interview with Licensed Practical Nurse (LPN) #1, on September 5, 2013, at 10:40 a.m., at the medication cart at the Orchid nursing station confirmed the multi-dose vial of Lidocaine was open and unlabeled. Review of facility policy, Accessing a Multi-Dose Via, revised August 15, 2008, revealed "...Guidance...the facility will receive from the pharmacy multi-dose vials dispensed and labeled as a resident-specific prescription item...vials will be labeled, after opening, with...resident's name...date and time...nurse's initials...multi-dose vials are to be discarded if...open and undated..." Interview with the Assistant Director of Nursing (ADON) in the ADON's office on September 5,	F 431	c) Maintenance Department will inspect the range top, grill, back splash, and can opener slot monthly to monitor for any additional preventative maintenance needs. Director of Maintenance/ Maintenance associate will report any needs for preventative maintenance to the Executive Director, Dietary Manager, and Assisted Living Coordinator. 4. a) The Dietary Manager/Director of Nutritional Services will report results from audits to the Performance Improvement Committee. b) The Performance Improvement Committee consisting of Executive Director, Director of Nursing, Medical Director, Director of Rehabilitation, Director of Health Information, Director of Clinical Nutrition, Director of Maintenance, Director of Environmental Services, Business Office Manager, Director of Recreational Services, and Staff Development Coordinator will review results. If it is deemed necessary by the committee, additional education may be provided; the process evaluated/revised and/or the audits reviewed for 3 months or until 100% compliance achieved.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 10 2013, at 1:40 p.m., confirmed the Lidocaine multi-dose vials come from the pharmacy without a patient label. The ADON also confirmed, that per facility policy, the vial should have a label of date, time opened, and label for the resident it was used for.	F 431	F431 1. The multi dose vial was removed from the medication cart and discarded on September 05, 2013.	9/05/2013
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	F 441	2. a)The Assistant Director of Nursing audited 100% of facility's medication carts on September 05, 2013 and found no other opened multi dose vials without a label or date. b) No resident receiving medications from a multi dose medication vial were affected by the alleged deficient practice. 3. a) The Staff Development Coordinator will educate 100% of licensed nurses on dating/labeling/initialing multi dose medication vials by September 27, 2013. b) The Director of Nursing/Assistant Director of Nursing will audit the medication carts weekly for compliance for 3 months. 4. a) The Director of Nursing/Assistant Director of Nursing will present results of audits to the Performance Improvement Committee.	9/05/2013

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/10/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445421	A. BUILDING _____ B. WING _____	09/05/2013

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F 441	Continued From page 11 (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to follow guidelines to prevent the spread of infection for thirteen out of twenty-seven residents. The findings included: Observation on September 3, 2013, at 12:00 p.m., in the main dining room revealed an ice scoop in the ice cooler. Further observation revealed the Certified Nursing Assistant (CNA #1) removed the ice scoop from the ice chest, scooped the ice, touched the scoop to the resident's water cup, and returned the ice scoop to the ice chest. Further observation revealed CNA #1 repeated the same procedure for thirteen out of twenty-seven residents served in the main dining room. Interview with CNA #1 on September 3, 2013, at 12:05 p.m., in the main dining room confirmed the ice scoop was stored in the ice cooler. Further interview with CNA #1 confirmed "...this is how...always do it..." Interview with the Dietary Manager on September 3, 2013, at 12:20 p.m., in the main dining room confirmed the ice scoop was not to be stored in the ice cooler.	F 441	b) The Performance Improvement Committee consisting of Executive Director, Director of Nursing, Medical Director, Director of Rehabilitation, Director of Health Information, Director of Clinical Nutrition, Director of Maintenance, Director of Environmental Services, Business Office Manager, Director of Recreational Services, and Staff Development Coordinator will review results. If it is deemed necessary by the committee, additional education may be provided, the process evaluated/revised, and or the audits reviewed for 3 months or until 100% compliance is achieved. F441 1.The ice cooler and scoop were immediately cleaned and all staff in dining area were educated on how to appropriately distribute ice from the ice cooler and store the ice scoop by Dietary Manager on September 03, 2013. 2. a) The ice cooler and scoop were immediately cleaned and all staff in dining area were educated on how to appropriately distribute ice from the ice cooler and store the ice scoop by Dietary Manager on September 03, 2013.	9/03/2013 9/03/2013

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			b) No other residents were affected by the alleged deficient practice after ice cooler and ice scoop was cleaned. 3. The Staff Development Coordinator will educate 100% licensed nurses and certified nursing assistants on infection control standards regarding distribution of ice from the ice cooler and appropriate storage of the ice scoop by September 27, 2013. b) The Director of Nursing/Assistant Director of Nursing will audit ice distribution and ice scoop storage practice for compliance weekly for 3 months. 4. a) The Director of Nursing/Assistant Director of Nursing will present results of audits to the Performance Improvement Committee. b) The Performance Improvement Committee consisting of Executive Director, Director of Nursing, Medical Director, Director of Rehabilitation, Director of Health Information, Director of Clinical Nutrition, Director of Maintenance, Director of Environmental Services, Business Office Manager, Director of Recreational Services, and Staff Development Coordinator will review results. If it is deemed necessary by the committee,	